# NURSING IN MARYLAND HOSPITALS –

## In Critical Condition?

A Report by the Task Force on Nursing Issues

of the

Maryland Hospital Association

December, 1980



The Maryland Hospital Association, Inc.
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# FOREWORD

The hospital nurse: the personification of compassion, kindness and competence in our society. While the public's perception of and esteem for many other professions faltered amid social problems and changes in recent years, nurses continued to command a high measure of public and patient confidence, respect, and affection.

But while nursing appeared outwardly immune from the social upheavals of the last decade and a half, internally the profession and the people who practice it have been affected profoundly by economic, social, and political shifts in American life. Just two decades ago there was no significant national shortage of registered nurses caring for patients in the hospital setting. Nursing was one of a handful of careers considered accessible to and suitable for women. It was a simpler time. Physicians were the key providers of medical care, and it was thought nurses were their hardworking handmaidens.

The practice of medicine was predominantly male; nursing was overwhelmingly female. Roles and responsibilities seemed clear and unquestioned.

Today, a nurse shortage grips the nation. While in Maryland the shortage is about 14 percent, estimates are as high as 30 to 40 percent for other regions of the country. Annual turnover rates are skyrocketing. The women's movement of the 1970s has altered permanently the way American women, including nurses, think about themselves from personal, career, legal, economic, and philosophical viewpoints. Burgeoning medical technology, a heightened public concern about health, and some radical alterations in attitudes about how health care should be delivered in this country have continued to change both the challenges and the work environment confronting nurses. Nursing is a profession truly in transition. The shortage of hospital nurses is but one of the myriad problems facing the nursing profession.

In the late 1970s, the hospitals of Maryland began to realize that the then slight shortage was not a transient phenomenon, but rather a trend. Initial efforts to deal with it were piecemeal; their success spotty. In the autumn of 1979, the hospitals, working with the Maryland Hospital Association, decided to take a comprehensive look at the problem. Under MHA's aegis, a task force on nursing issues, including administrators, nurses, nursing directors, nurse recruiters, and educators was formed. The mandate: find out how severe the shortage and turnover rates are and recommend actions which hospitals -- individually and collectively -- government on all levels, educational institutions, and the public can take to revitalize the profession of hospital nursing, ease the shortage, and provide patients with an even higher quality of care, both immediately and in the future.

This report is the result of more than six months of interviews, research, debate, and discussions. A statewide survey was taken at the outset to determine the severity of the nurse shortage and job turnover rates in Maryland. While it is capsulized in Part I of this report, a more detailed version appears as an appendix to this document.

Those looking for quick or easy solutions to either the nurse shortage or the other complex problems confronting hospitals and nurses will not find them in this report.

The shortage and its accompanying ills were years in their development. There is little to indicate that they will not be the same in their undoing and ultimate solution.

Hospitals, government, and educational institutions all have a tremendous stake in finding meaningful solutions to the problems. But it is the public and, more specifically, the hospital patient who will be most affected and it is upon those institutions the patients will depend to ensure that they have the nursing care they need when they need it.

## SUMMARY OF RECOMMENDATIONS

### RECOMMENDATIONS TO THE GOVERNOR AND THE MARYLAND GENERAL ASSEMBLY

I. Scholarships to all types of nursing education institutions should be offered by the state of Maryland, linked to a commitment from the recipient to work for an agreed time in a Maryland hospital following graduation.

II. The state of Maryland, with the aid of a national demonstration project grant from the federal government, should launch a pilot program offering career preparation and economic support to individuals who want to enter or reenter the job market and make nursing their new career. Agencies such as the Maryland Commission for Women and community advocacy groups should be encouraged to participate and support this effort.

III. The Governor should request the necessary funding from the Maryland General Assembly to increase the staff and resources of the Maryland Board of Examiners of Nurses. The Governor should further investigate what legislation might be necessary to regularly obtain basic data on the distribution and professional status of nurses, possibly as a part of the relicensing process.

### RECOMMENDATIONS TO THE NEW MARYLAND COMMISSION ON NURSING

I. The new Maryland Commission on Nursing should, as part of its work, evaluate the role and impact of LPNs in the health care system and in particular the modern hospital.

II. The Maryland Commission on Nursing should, in its consideration of the aspects of nurse education, study the academic relationships and disparities between the various levels of nurse education and formulate actions to ensure compatibility between levels and a smoother pursuit of higher education.

III. The task force urges the state Health Planning and Development Agency to take the necessary steps to amend the state health plan to include a component on nursing. It is urged that this be done in close cooperation with the new Maryland Commission on Nursing.

### RECOMMENDATIONS TO THE HEALTH SERVICES COST REVIEW COMMISSION, THE DEPARTMENT OF EDUCATION AND OTHER STATE AGENCIES

I. The Maryland Department of Education should establish, beginning with the 1982-83 school year, a health care careers program as part of the state's high school curriculum with a particular emphasis on nursing and a strong link to all nursing education programs at all levels.

II. The state of Maryland's Department of Education should work with all state nursing education programs to achieve expansion, which could be one area of study for the new Maryland Commission on Nursing.

III. Maryland hospitals and the Maryland Department of Education should establish greater and more formal links of communication, cooperation and shared resources between all nursing education programs and community hospitals.

IV. The Health Services Cost Review Commission should support hospitals' efforts to implement innovative programs to enhance nursing education, staffing, recruitment and retention and create additional educational opportunities in areas of Maryland where they are most needed.

V. The task force urges the state Health Planning and Development Agency to take the necessary steps to amend the state health plan to include a component on nursing. It is urged that this be done in close cooperation with the new Maryland Commission on Nursing.

RECOMMENDATIONS TO MARYLAND HOSPITALS

I. The hospitals of Maryland should make a concerted effort to encourage licensed practical nurses and other qualified and interested personnel to seek the additional training necessary to become registered nurses.

II. The hospitals of Maryland should renew and revitalize their campaign to recruit and retain nurses as well as encourage nurses who have left the profession to return. Innovative salary and benefit programs; prepaid refresher courses; subsidized day care facilities, possibly in the hospital complex itself; flexible working schedules; clinical education programs, and other creative techniques could make it personally and professionally desirable for nurses to remain in as well as return to nursing.

III. Maryland hospitals and the Maryland Department of Education should establish greater and more formal links of communication, cooperation, and shared resources between all nursing education programs and community hospitals.

IV. Hospitals should examine in detail their orientation programs, particularly for new nurses, to ensure a thorough grounding in all aspects of the institution's operations, structure, policy and procedures. The program should be reevaluated on a regular basis for currency and relevance.

V. The hospitals of Maryland, possibly through the Maryland Hospital Education Institute, should be given a forum to compare and improve their nurse orientation programs.

VI. Hospitals must not only continue to fight for improved salaries, but must address the economic concerns of nurses by trying to deal effectively with other influences directly related to the current shortage.

VII. The administration of each Maryland hospital, working in partnership with their nursing staff, should study the linkage between nurse responsibilities and salaries and strive for a system of salaries commensurate with responsibility and experience.

VIII. Hospitals should review their administrative structures -- budget and program planning, patient care and quality assurance committees, institutional planning committees, and other key decision-making bodies -- to ensure that nurse management participates at all levels of decision-making.

IX. Hospitals, working in partnership with nursing education programs, should give special attention and devote appropriate resources to providing student nurses with a comprehensive view of the hospital, including practical experience on all shifts and weekend work.

X. Hospitals should strongly consider the establishment of a system of clinical advancement to encourage nurses to further their education, broaden their skills, and link each step of the ladder to commensurate salary and benefit improvements.

XI. Hospitals should support and foster the use of multilevel management training programs for nurses entering and occupying supervisory positions. Particular emphasis should be placed on early recognition and development of potential management talent.

XII. Hospitals of Maryland should increase the use of flexible work shifts to give the nurse more opportunity to adjust professional and personal needs.

XIII. Hospitals should consider benefit options for nurses, providing opportunities for nurses to have a voice in the benefits offered them and a decision in what they can accrue or waive.

XIV. All Maryland hospitals using temporary nurse agencies should adhere to recognized guidelines which delineate the proper mechanism and procedures for acceptance, orientation, assignment, and/or evaluation of the individual agency nurse.

XV. Hospitals within the same geographic region should explore the advantages of regional pools to widen the supply of nursing personnel available to all.

XVI. Individual hospitals should assess the value of creating in-house nurse pools.

RECOMMENDATIONS TO THE MARYLAND HOSPITAL ASSOCIATION AND THE MARYLAND HOSPITAL EDUCATION INSTITUTE

I. A well-planned, concerted and continuing effort must be made by Maryland hospitals -- possibly through the Maryland Hospital Association and the Maryland Hospital Education Institute -- to provide adequate, attractive information on health careers, most particularly nursing, to high school guidance counselors in public, private, and parochial schools.

II. The Maryland Hospital Association, with respect to the proposed ANA resolution -- that there be two levels of nursing: professional and an assisting/technical category -- should indicate that 1985 is a wholly unattainable target date.

III. The Maryland Hospital Association should assist hospitals in evaluating and strengthening nurse internship programs. Greater effort should be made to demonstrate additional experimental and prototype programs built on the experience gained to date.

IV. The Maryland Hospital Education Institute should assist nurses and hospitals in identifying the key clinical and management education needs of nurses and then devise a long-range program to meet those needs.

RECOMMENDATIONS TO OTHER PROFESSIONAL ORGANIZATIONS

I. The Medical and Chirurgical Faculty of Maryland should establish, as part of its continuing education for physicians, a program to improve and heighten human relations skills with the objective of increasing physician sensitivity to the dignity and abilities of their health care colleagues.

## THE PROBLEM TODAY

### HOW SERIOUS IS THE CURRENT SHORTAGE?

The American Nurses' Association (ANA) and the American Hospital Association (AHA) estimate there will be a nationwide shortage of at least 100,000 nurses by 1982. In every region of the country, state hospital associations and local councils report that their members lack sufficient numbers of qualified nurses to properly staff their beds.

Health care institutions are closing down beds and, in some cases, entire units. Hospital administrators are compelled to resort to temporary nurse employment agencies and other more extreme means to ensure quality patient care. What is perhaps even more discouraging is that the number of graduates from hospital-based "diploma" nursing schools is on the wane. Moreover, there is a dearth of qualified nurses with advanced training and education.

And the situation shows no immediate signs of improvement. Recent studies prove that the number of individuals entering nursing schools leveled off between 1975 and 1977 and actually declined beginning in 1978.

Nurses are employed in a variety of settings: hospitals, nursing homes, schools, business and industry, government, and other agencies, public and private. Almost all the evidence indicates that hospitals and, to a lesser degree, nursing homes, are feeling the brunt of the shortage. National organizations concerned with nursing seem to verify this conclusion. A National Association of Nurse Recruiters report, released early this year, stated flatly: "Every region of the United States is experiencing an acute, severe shortage of hospital registered nurse manpower."

Surveys by state hospital associations add further weight to the theory that the national nurse shortage, about which so much has been written and said, is, more accurately, a hospital nurse shortage.

A California Hospital Association study focusing on the third quarter of 1978 identified a 17 percent shortage -- that via a comparison of the number of budgeted nurse positions to the number of existing vacancies. The Association also measured the RN job turnover rate for the same period and pegged it at a whopping 63 percent. A sampling of the situation as measured in other states revealed shortages of seven percent in Pennsylvania, 12 percent in the Milwaukee area, 33 percent in western Tennessee, 21 percent in Arizona, and 14 percent in Texas.

But what about Maryland? The task force deemed it essential that at the outset of its work it have as clear a conception as possible of the extent of the shortage and turnover rate.

To the panel's amazement, it was found that not one agency, public or private, had ever accumulated any reliable data on a statewide scale. Not one arm of the state government, including those agencies that license and regulate nurse activities, and no private organization of nurses had dependable information on the extent of the shortage, on the number of licensed nurses at work in the state in some form of nursing, or those who have left the profession.

Therefore, to focus on Maryland's problem, the task force made it their first objective to measure as precisely as possible the registered nurse and licensed practical nurse vacancy and turnover rates. The timing for such a survey was ideal. Since the Task Force organized itself late in the autumn of 1979, the group decided to base its study on calendar year 1979.

In all, more than 50 Maryland hospitals were surveyed. The raw data received was then grouped by seven variables:

1. Rural/Urban
2. Health System Agency area
3. Number of beds
4. Presence or absence of interns and residents
5. Wage rate (minus benefits)
6. Total wage rate (with benefits)
7. Length of stay

Just as national looks at the nursing shortage have found the problem affecting all parts of the country, the MHA task force found that Maryland was "America in miniature" once again.

Survey results revealed a shortage affecting all Maryland hospitals about equally. Statewide, the vacancy rate was approximately 14 percent. The problem was slightly more severe in the two metropolitan areas -- Baltimore and Washington -- than in rural areas. Of the two metro regions, Washington with a 14.5 percent shortage fared only slightly better than the Baltimore area with its 14.8 percent shortage.

Hospitals in Western Maryland and on the Eastern Shore were faring better than their urban-suburban colleagues. The average shortage in the western part of the state was about 11 percent in 1979, while hospitals on the Shore reported a vacancy rate of slightly more than 12 percent.

The shortfall of nurses appeared most troublesome in

institutions with longer lengths of stay (LOS) for patients. Hospitals with LOS of 6.2 days or less were experiencing about a 10 percent shortage -- significantly below the statewide average. But institutions with longer LOS told the task force their shortage was an average 18.9 percent.

Smaller hospitals were having a tougher time than larger ones, according to the results. Average vacancy rates of around 16 percent were the rule for hospitals of 250 or fewer beds. Larger hospitals had an average shortage of between 10 and 11 percent. It should be pointed out that the small hospitals, often in rural areas, have smaller labor markets from which to draw and a tougher time attracting new graduates.

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## IS THE JOB TURNOVER RATE FOR NURSES AGGRAVATING THE PROBLEM?

As if a chronic shortage were not enough, Maryland hospitals must cope with a statewide job turnover rate of about 27 percent. Once again, all hospitals seem to be dealing with about the same scope problem. Factors such as location, length of stay, and presence or absence of interns appeared to have little or no effect on what appears to be a restless and changing work force.

Turnover varied little between RNs and LPNs statewide, but a curious phenomenon was noted when urban and rural institutions were compared. The turnover rate for RNs in urban hospitals was slightly more than 35 percent, compared to 25 percent for LPNs. But in rural hospitals, RN turnover was only 24 percent, while the rate for LPNs was close to 31 percent. A more detailed distillation of the survey is appended to this report.

Clearly, then, the hospital nurse shortage in Maryland is critical. It is further complicated by a job turnover rate which keeps health care institutions in a perpetual state of flux, constantly compelling them to try new strategies to attract nurses to their staffs, and retain them once they are hired.

But the vacancy and turnover statistics only describe today's problem. They do not explain the reasons for it. To achieve an understanding of the complex and often conflicting influences that have helped create the current situation, the task force examined a number of topics that affect the nurse at work today, the new graduate produced by the educational system, and individuals entering into or returning to nursing as a career.

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## FORCES, FACTORS, AND INFLUENCES

It is clear from all the studies, surveys and debates, locally

and nationally, that:

* Nursing school enrollments are not increasing at a pace suitable to meet the growing demand.

* Nursing is not attracting as many young people as it once did.

* Many young nurses spend a relatively short time at work in a hospital setting before switching to another area of nursing or leaving the profession altogether.

* Nurses who leave the profession are not being induced to return in large numbers.

* There is much shifting of personnel between hospitals as nurses seek salaries, working conditions, job fulfillment, and advancement more in harmony with personal as well as career goals.

* All these factors must be dealt with if a meaningful and lasting solution to the problem is to be found.

A study made public in the July 1980 issue of RN magazine indicated that one-third of this nation's nurses have left practice. A poll conducted for the magazine reached 3,700 working and non-working nurses in southern Florida and indicated an overall dropout rate in the profession there of 30 to 40 percent.

The most often stated and apparently most important reason given for leaving nursing was diminishing patient contact due to an increase in other work demands. Of the nonworking nurses, 35 percent gave understaffing, excessive workloads, and exhaustion as other reasons for dropout. One-third left for family reasons. Only 13 percent of those surveyed left because they could make more money elsewhere.

The survey concluded that if the 3,000 RNs in that region who have left the field could be persuaded to return, the nursing shortage would end immediately.

The task force examined material collected in the Maryland survey and those of other states; reviewed what has been written and said in the general press, professional journals, and other health care publications; and discussed with dozens of individuals not only the nurse shortage but the overall state of the profession as well.

As the group worked, nine general issue areas emerged:

1. The decline of nursing as a career choice

2. The nature of nursing education

3. Orienting the new nurse

4. Salaries

5. Wage compression and other economic concerns

6. Professional fulfillment

7. Career growth

8. Hospital personnel policies

9. Temporary nurse agencies

It is upon these nine issues then, that the task force based its report.

Addressing the areas forthrightly and imaginatively would:

* Help attract more individuals to nursing by stepping up efforts to reach not only the traditional audiences of such efforts, but new ones as well.

* Make nursing education more accessible and responsive to both the potential student and the hospitals who will employ the graduate nurse.

* Ensure that initial professional experiences of new nurse graduates are more positive, thus preventing discouragement and encouraging a solid work attitude.

* Encourage change and innovation in hospital personnel policies as they relate to nursing.

* Promote the kind of economic, education, and job satisfaction opportunities for nurses in the hospital setting that will help stabilize the work force, lessen nurse "burnout," and stem the rising rate of nurses dropping out of the profession.

* Aid hospitals in building permanent, productive, stable nursing staffs that take an active role both in formulating the policies and procedures which affect them and in improving the quality of patient care.

The hospital's ability to hire and retain a good nursing staff is the result of the interplay, sometimes extremely subtle, between the nine issue areas just cited.

## THE DECLINE OF NURSING AS A CAREER CHOICE

The initial decision of an individual to pursue the demanding training required of a registered nurse is the result of many factors, some of which cannot be directly influenced by hospitals.

Many individuals, however, can be influenced if those who have a stake in the future of the nursing profession make a concerted effort to:

A. target the proper audience: The opportunities inherent in the nursing profession should be shared with those individuals most likely to pursue nursing as a career, and

B. communicate the message in a manner designed to appeal to the audience: The hospital's ability to successfully reach its target will depend on the vehicle used.

The traditional target for guiding individuals into nursing careers has been high schools and, to a lesser extent, colleges.

Campaigns to attract high school juniors and seniors to careers in nursing have generally been waged by the schools of nursing. When the hospital-based schools of nursing were much more prevalent, they recruited actively in the high schools for students. Because of their affiliations with the schools, hospitals had a form of direct contact with those individuals who would enroll and, very likely, eventually join their nursing staffs.

The disbanding of so many hospital schools of nursing (only four are left in the state of Maryland, where once many flourished) broke an important link between potential nursing students and the educational-health care institutions which eventually would train and employ them.

Community colleges and four-year colleges and universities have strong recruiting programs. But these schools offer a variety of curriculum choices and do not, as a rule, place particular emphasis on a particular subject area. Hence, students rarely perceive nursing as being different from other professional schools.

In the past, clubs existed within the secondary schools that encouraged what career inclinations a pupil may have displayed. But organizations such as the Future Nurses of America and the Future Teachers of America have lost both relevance and popularity.

Another critical element in the process of influencing young people to enter the nursing profession has been the high school guidance counselor.

In secondary schools in Maryland, an increasing emphasis has been placed on counselors and their role, not only in guiding

students toward appropriate choices for the educational and vocational future, but in structuring their high school experience to provide them with maximum preparation for that future. Further, there are indications that high schools have de-emphasized traditional female-dominated professions in favor of careers which previously attracted mostly males.

The task force considered what currently is being done by hospitals, individually and collectively, and what efforts are being made by the schools of Maryland to guide youngsters into career areas where there are critical needs for human resources and attractive economic opportunities for trained personnel.

These efforts were found lacking by both nursing educators and employers of nurses.

The Maryland Department of Education could provide a pivotal push towards helping to relieve the nurse shortage. Through a combination of creativity in curriculum efforts in guidance and counseling cooperation with the private sector and academic incentives for students already inclined to health care careers, more young people can be convinced that such careers, particularly nursing, are highly desirable and needed.

RECOMMENDATION: THE MARYLAND DEPARTMENT OF EDUCATION SHOULD ESTABLISH, BEGINNING WITH THE 1982-83 SCHOOL YEAR, A HEALTH CARE CAREERS PROGRAM AS PART OF THE STATE'S HIGH SCHOOL CURRICULUM.

This program could be modeled on the highly successful vocational-technical education programs already an established part of this state's school system. Vo-Tech has done an admirable job of encouraging young Marylanders to enter a variety of trades by giving them academic credit and incentives for training and work in business, agriculture, related construction professions, and others as part of their high school studies.

Health care jobs deserve this kind of priority and support. High school courses on basic health care related subjects could be introduced as electives to help spark students' interest. Academic credit could be awarded for approved paid or volunteer part-time work in hospitals and other health care institutions. Emphasis should be on attracting both women and men to this program and to make such a program relevant not only to students considering careers in nursing but in other health areas as well.

RECOMMENDATION: SCHOLARSHIPS TO ALL TYPES OF NURSING EDUCATION INSTITUTIONS SHOULD BE OFFERED BY THE STATE OF MARYLAND, LINKED TO A COMMITMENT FROM THE RECIPIENT TO WORK FOR AN AGREED TIME IN A MARYLAND HOSPITAL FOLLOWING GRADUATION.

In the late 1950s and 1960s, the state inaugurated a similar program to combat an apparent teacher shortage in Maryland. A combination of rapidly increasing student population and a vigorous

school construction program had made it impossible for the female-dominated teaching profession to produce enough teachers. The scholarship programs which channeled students to what was then Maryland's system of "teachers' colleges" was successful. Combined with a program of draft deferments for males, this program increased the number of men and women entering education as a livelihood and ended the shortage of teachers in Maryland.

RECOMMENDATION: A WELL-PLANNED, CONCERTED, AND CONTINUING EFFORT MUST BE MADE BY MARYLAND HOSPITALS, POSSIBLY THROUGH THE MARYLAND HOSPITAL ASSOCIATION AND THE MARYLAND HOSPITAL EDUCATION INSTITUTE, TO PROVIDE ADEQUATE, ATTRACTIVE INFORMATION ON HEALTH CAREERS, MOST PARTICULARLY NURSING, TO HIGH SCHOOL GUIDANCE COUNSELORS IN PUBLIC, PRIVATE, AND PAROCHIAL SCHOOLS.

While this effort should be statewide and should be made in cooperation with nurse personnel and nurse recruiter organizations, a strong community-based program is essential. All hospitals must actively communicate with and encourage students in their local schools who demonstrate interest in nursing, regardless of the hospitals' immediate personnel needs. Among the ways which this can be accomplished are: enthusiastic participation in school career days, vigorous public speaking programs, recruitment of individuals for volunteer or other participation in hospital activities, and providing hospital personnel to counsel and communicate with future nurses.

RECOMMENDATION: THE STATE OF MARYLAND, PERHAPS WITH THE AID OF A NATIONAL DEMONSTRATION PROJECT GRANT FROM THE FEDERAL GOVERNMENT, SHOULD LAUNCH A PILOT PROGRAM OFFERING CAREER PREPARATION AND ECONOMIC SUPPORT TO INDIVIDUALS WHO WANT TO ENTER OR REENTER THE JOB MARKET AND MAKE NURSING THEIR NEW CAREER. AGENCIES SUCH AS THE MARYLAND COMMISSION FOR WOMEN AND COMMUNITY ADVOCACY GROUPS SHOULD BE ENCOURAGED TO PARTICIPATE AND SUPPORT THIS EFFORT.

While high school students are quite rightly the primary target of efforts to attract individuals to the nursing profession, the current shortage and the likelihood of its continuance make it important that other sources of potential human resources be explored.

Unemployment is at an extremely high level, both nationally and in Maryland. Surely the ranks of those unemployed include many individuals with the intelligence and skill potential to be good hospital nurses. By undertaking a serious effort to reach the unemployed and by structuring the kind of training and retraining programs that are accessible and offering appropriate economic incentives, the state of Maryland could demonstrate a commitment, in cooperation with the private sector, to make progress in reducing the jobless rate.

The displaced homemaker and the married woman seeking employment to supplement a family income in times of burgeoning inflation already have skills and experiences directly applicable to the nursing

profession. Efforts to attract these individuals to nurse training programs, tailored to meet their special needs, should be established.

RECOMMENDATION: THE HOSPITALS OF MARYLAND SHOULD RENEW AND REVITALIZE THEIR CAMPAIGN TO RECRUIT AND RETAIN NURSES AS WELL AS ENCOURAGE NURSES WHO HAVE LEFT THE PROFESSION TO RETURN. INNOVATIVE SALARY AND BENEFIT PROGRAMS, PREPAID REFRESHER COURSES; SUBSIDIZED DAY CARE FACILITIES, POSSIBLY IN THE HOSPITAL COMPLEX ITSELF; FLEXIBLE WORKING SCHEDULES; CLINICAL EDUCATION PROGRAMS, AND OTHER CREATIVE TECHNIQUES COULD MAKE IT PERSONALLY AND PROFESSIONALLY DESIRABLE FOR NURSES TO REMAIN IN AS WELL AS RETURN TO NURSING.

This subject will be discussed further as the task force comments on Hospital Personnel Policies. But it must be pointed out and strongly stressed that if even a portion of the qualified, competent nurses in Maryland who have left the profession could be persuaded to return, the nursing shortage could be alleviated.

## THE NATURE OF NURSE EDUCATION

Once the important decision to pursue a career in nursing is reached, the individual is immediately confronted with a second decision; one that is confusing and hinges on a number of elements including economics, cultural and community background and long-range career goals.

That decision is: What kind of nurse should I be?

There are four distinct ways by which a person can achieve the status of "nurse."

First and most basic is the one-year program, often hospital based, leading to the designation of licensed practical nurse. Schools of practical nursing also are operated privately and by state governments. Twenty such schools are open today in Maryland. But the individual who successfully completes LPN training is confronted with a career and educational system that makes it extremely difficult to progress to higher professional status.

The path to the position of registered nurse, however, is not so clear a choice.

There are three educational routes to becoming a registered nurse in the state of Maryland.

A high school graduate can enroll in any of 13 two-year college nurse-training programs. At the end of two years, the successful student has earned an Associate of Arts degree. By passing the examination from the Maryland Board of Examiners of Nurses, the designation of registered nurse is attained.

A high school graduate also can enroll in one of the state's four hospital-based nurse education programs, which range in length from 27 months to 33 months. The successful student earns a "diploma" or, in a handful of cases, an Associate degree and takes the same examination for the RN license as the community college graduate.

Enrollment in a full four-year college or university following high school graduation is the third route. Upon graduation, the student earns a bachelor of science degree in nursing, takes the same required "state board" exam and, if successful, also is a registered nurse. In Maryland, six institutions offer baccalaureate programs in nursing.

In studying the effect of education on the current shortage and other problems in the profession, the task force gathered considerable and revealing data on enrollment and graduation trends in both licensed practical and registered nursing programs.

With the data available, the task force concentrated on the years 1965 through 1978. This period was particularly appropriate

since it encompassed the onset of hospital rate regulation in Maryland, the disappearance of many hospital-based diploma schools, the profound social changes brought on by the women's movement in America, and the considerable changes in education and the public's perception of it.

A review of this information turned up a number of trends.

The number of persons admitted to hospital-based RN programs declined between 1965 and 1978. In contrast, there was a gradual increase in baccalaureate program enrollments and an even steeper rise in community college programs.

As pointed out earlier and worthy of reemphasis, this period was the era in which the number of hospital-based schools dropped dramatically. This was due in part to the rising cost of operating those institutions and the establishment of state-level rate regulation which worked to eliminate reimbursement for those hospital costs not directly connected with patient care.

It also was during this same period that the state of Maryland made a mammoth financial commitment to the community college system, and determined to make higher education accessible to the entire population and to gear that education toward practical career application. The community college emphasis was on business, nursing, law enforcement, and other professions which a student could enter with an associate-level degree.

But since 1973, total enrollments have decreased. This can be traced once again to the fading of hospital-based schools and, to a lesser extent, cutbacks in community college programs brought on by fiscal constraints at the county and state levels. College-level nursing school enrollments continued to increase. These trends reversed somewhat in 1977 and 1978 when community college nursing enrollments declined, university programs continued to grow, and diploma school admissions stabilized.

Although the educational system attempted to compensate for the massive diploma school closings by opening more college-based programs with larger classes, the task force found that this effort was not sufficient to meet the demands of a growing health care system.

Further, not all individuals seeking a nursing career could afford the time and financial resources required for a college-based program. Consequently, a different type of nurse was being trained. Career orientation of the B.S. graduated nurse varied considerably from the diploma graduate, particularly in terms of commitment to staff nursing.

The results of a recent survey by the National League for Nursing is even more cause for concern.

In a poll of state-approved schools of nursing, the League found both the number of admissions and the number of graduates down during the 1978-79 academic year.

The slight drop in graduates, about one percent, was the first in several years. But the nearly three percent slump in admissions was a continuation of a three-year trend. The League's president called the statistics evidence of "a systematic decline in the preparation of new nurses."

One of the most complicated components of the current shortage and one of the thorniest problems the profession must confront is the compatibility of and the ability to interchange the community college, diploma school, and baccalaureate degree nurse in the hospital setting. The issue of the multilevel education system is the core of the challenge facing nursing education in the decade ahead. It is, ironically, an issue that has plagued the profession for nearly a quarter of a century.

This system creates considerable havoc within the profession. There is a marked lack of coordination between curricula and clinical experience at all three levels. Thus each kind of graduate -- community college, hospital, or university trained -- is in theory prepared to function equally in the hospital setting. In practice, however, he or she may be the product of very different classroom and patient care training experiences.

It is then up to the hospitals to cope with the challenge of reconciling these differences, developing common levels of skills and bridging what can sometimes be an extremely wide educational and practical experience gap.

Since 1970 in Maryland, the rate of increase in the total number of nursing graduates has been about 100 percent. But with the decline in hospital-based schools, it is not surprising to discover that while the rate is increasing, the actual number of new graduates is slipping.

What's more, community college enrollments have stabilized, while the number of graduates has increased. This indicates fewer dropouts from that program.

The growth of the highly accessible community college programs may also be one reason for the dramatic decline in enrollments and graduations from licensed practical nursing programs. The future of LPNs in the modern hospital is certain to be the subject of intense debate in the years ahead. Whatever the outcome, it surely will impact both the educational system and the hospital.

If burgeoning health care technology, the increasing intensity of patient care and the nature of the nursing education and the profession are resulting in a reduced demand for LPNs in hospitals and fewer individuals pursuing licensed practical nursing, two key questions must be addressed:

* Should LPN training be phased out and existing LPNs be encouraged to become registered nurses?

* Can resources now being used to produce LPNs be better utilized toward increasing the number of RNs?

Since the demand for licensed practical nurses in acute care hospitals is declining, it may be inappropriate to encourage individuals to enter the profession. New LPNs, unable to find satisfying hospital employment, may well experience the kind of frustration that will compel them to abandon the health care field entirely. Thus, valuable human resources will be wasted. A phase out of LPNs, however, is a major step and one that should not be taken lightly.

RECOMMENDATION: THE NEW MARYLAND COMMISSION ON NURSING SHOULD, AS PART OF ITS WORK, EVALUATE THE ROLE OF AND REVIEW THE IMPACT OF LPNs ON THE HEALTH CARE SYSTEM AND, IN PARTICULAR, THE MODERN HOSPITAL.

RECOMMENDATION: EACH HOSPITAL IN MARYLAND SHOULD MAKE A CONCERTED EFFORT TO ENCOURAGE LICENSED PRACTICAL NURSES AND OTHER QUALIFIED AND INTERESTED PERSONNEL TO SEEK THE ADDITIONAL TRAINING NECESSARY TO BECOME REGISTERED NURSES.

Hospitals should put together a variety of aids and incentives to encourage LPNs to become RNs, including scholarship help and flexible scheduling.

In examining statistics on the growth of community college nursing programs, it became apparent to the task force that these programs represent the most logical mechanism both for training vast numbers of new nurses and providing the necessary refresher education to enable nurses who have left the field to return to it with confidence and competence.

Again, because of the decline of hospital schools and the expense of four-year colleges, there is a strong and growing demand for community college nurse training.

Evidence collected by the task force demonstrates that many students are being turned away from these programs. They simply cannot accommodate all of those who wish to enroll. An informal task force survey found that all community colleges in the state which kept such records reported more applicants than available slots.

If an effective job is done of bringing significant numbers of new students into nursing schools and encouraging LPNs to become RNs, additional capacity will be needed in the community college programs.

RECOMMENDATION: THE STATE OF MARYLAND'S DEPARTMENT OF EDUCATION SHOULD WORK WITH THE STATE'S NURSING EDUCATION PROGRAMS TO ACHIEVE

EXPANSION, WHICH COULD BE ONE AREA OF STUDY FOR THE NEW MARYLAND COMMISSION ON NURSING.

Besides a considerable fiscal commitment from the state and local governments to achieve this, a new and creative approach to the relationship between all nursing schools as educators of future nurses and hospitals as their future employers is, in the opinion of the task force, a must.

RECOMMENDATION: MARYLAND HOSPITALS AND THE MARYLAND DEPARTMENT OF EDUCATION SHOULD ESTABLISH GREATER AND MORE FORMAL LINKS OF COMMUNICATION, COOPERATION, AND SHARED RESOURCES BETWEEN ALL NURSING EDUCATION PROGRAMS AND COMMUNITY HOSPITALS.

More exchange of ideas and participation from the hospitals to the nursing schools -- particularly community colleges -- in the areas of curriculum, clinical training content, and postgraduate follow-up to orient the new nurse on the job; and better channels of communication between nurses, physicians, and hospital management could be critical factors in the success of expanded community college programs.

The colleges and the hospitals should explore the possibility of allowing the student nurse, if possible, to choose, midway through training, a hospital for clinical work. This would foster a relationship between the nurse, while still a student, and the institution.

The task force also believes the problem of nursing school facilities could be attacked on a second, equally effective front.

The survival of the hospital-based school is essential and incentives should be offered hospitals to expand in a limited way the number of hospital schools of nursing in Maryland. This will be possible only with the aid and strong support of the Health Services Cost Review Commission, the State Department of Health and Mental Hygiene, the State Department of Education, the new Maryland Commission on Nursing, and the legislative and executive branches of government.

RECOMMENDATION: THE HEALTH SERVICES COST REVIEW COMMISSION SHOULD SUPPORT AND FACILITATE HOSPITAL EFFORTS TO IMPLEMENT INNOVATIVE PROGRAMS TO ENHANCE NURSING EDUCATION, STAFFING, RECRUITMENT AND RETENTION, AND CREATE ADDITIONAL EDUCATIONAL OPPORTUNITIES IN AREAS WHERE THEY ARE MOST NEEDED.

A revival of the hospital-based school could be one way to ease the pressure on community colleges to expand.

The task force also reviewed problems experienced by diploma school graduates in either continuing their educations or translating their diploma school studies into credits applicable to the pursuit of associate or baccalaureate degrees.

This lack of standardization in curriculum and certification is unfair to the well-educated and competent graduate of a diploma school. The situation ultimately can lead to frustration because the diploma school nurse, unable to convert his or her school training into academic credits toward a degree, will find opportunities for advancement limited.

RECOMMENDATION: THE MARYLAND COMMISSION ON NURSING SHOULD, IN ITS CONSIDERATION OF THE ASPECTS OF NURSE EDUCATION, STUDY THE ACADEMIC RELATIONSHIPS AND DISPARITIES BETWEEN THE VARIOUS LEVELS OF NURSE EDUCATION AND FORMULATE ACTIONS TO ENSURE ACADEMIC COMPATIBILITY BETWEEN LEVELS AND SMOOTHER PURSUIT OF HIGHER EDUCATION.

The task force believes that, given the present industry requirements for nurses, the diploma program must remain a viable and valuable resource of training nurses. Because it strikes a balance between the two-year program with its necessarily limited clinical phase and the more academically-oriented baccalaureate program, the diploma school is producing an important professional in the health care field. Of equal importance is the fact that elimination of diploma programs might only serve to exacerbate the existing shortage. Until the system can compensate for the loss of these graduates, diploma programs must be retained, if not strengthened.

As noted earlier in this report, the number of graduates from university schools of nursing has been increasing steadily in recent years.

The nurse today who enters the profession with a Bachelor of Science degree has by all standards the brightest outlook for the future, professionally and financially, and the most flexibility in choosing areas of specialization. As more and more individuals have entered nursing with a college degree, the conflict and controversy over the multilevels of nurse education have sharpened. With each nurse exposed to distinct levels of academic and clinical training, there naturally has arisen the contention that levels of training should define levels of practice in nursing.

Changes in the educational system and the nursing profession have polarized the issue in recent years, but the dilemmas surrounding "entry into practice" have roots reaching back into the late nineteenth century.

Because a vast majority of nurses were (and are) women, the profession has been perceived by society as an expression of womanhood.

The nineteenth century philosophy of rigid roles for men and women helped confine nursing, as a female profession, to lower educational and economic strata.

The masculine model of our social order dictated that the diagnosis and treatment of disease was a male function, while

personal care, empathy, and teaching were female roles. As the demand for health care expanded in the late 1800s and early 1900s, nursing both flourished and languished. It flourished in a remarkable growth in the number of nurses and nursing schools, the founding of associations of nurses and publications such as the American Journal of Nursing.

But it languished in its inability to control either its numbers or its access to consumers of nursing services. For example, between 1800 and 1910, the number of nursing schools and nurses in America multiplied 75-and 52-fold respectively. As the number of schools increased, the profession attempted to define educational standards.

But because most nurses were drawn from working class families and in such families prolonged education, especially for females, was out of the question, nursing education was destined to be labeled "vocational training."

A second and equally potent factor is that nursing accepted the cultural leadership of medicine. The nurse's image as nurturer, moral guardian and efficient manager did not require long, highly technical training.

As American society evolved, notably in its attitudes toward women, the nursing profession evolved and changed as well. Increasing numbers of young women aspired to college and university education. Women entered medicine and other health care professions that were once bastions of male domination. Health care technology developed at a startling pace, requiring nurses to develop new skills "on the job" in order to be able to provide the most sophisticated level of patient care. As nursing practice became more technical and more demanding, so did the educational program.

Many in the nursing field, particularly educators, soon developed the view that nursing as a profession required a baccalaureate degree. In 1965, the American Nurses' Association approved what has since become known as the "1985 Resolution" -- an "entry into practice" proposal designed to provide a major reform within the framework of nursing education.

The resolution calls for all professional nurses entering the profession in 1985 and after to possess bachelor's degrees. All those licensed as registered nurses at the 1985 implementation date would be granted the "professional nurse" designation, but nurses without bachelor's degrees and registered nurse status would be classified as "technical nurses."

Thus, the problem of disparity both in education and job responsibility between nondegree and baccalaureate nurses would presumably be solved, according to the ANA.

As expected, the resolution, which would require legislation

to be enacted in each state to become effective, resulted in a controversy that rocked not only the nursing profession, but the entire health care industry.

Its supporters declare it will "upgrade" the profession by demanding higher qualifications and more uniform nurse training standards. Moreover, they contend that besides clarifying the mission of educational institutions, the dual levels of nurse practice will permit hospitals to clearly delineate responsibilities between the technical and professional nurse and, presumably, offer employees compensation that reflects the difference in training and job responsibility.

Opponents of the resolution argue that it would needlessly increase the cost of nurse training by requiring potential nurses to obtain a college degree, thus further aggravating the national shortage by actively discouraging people from entering the field. Many of the proposal's opponents view it as an effort to limit and isolate entry into nursing.

Backers also believe that college graduates, by virtue of their education, merit wider responsibilities and higher salaries. Critics counter with the claim that because baccalaureate programs provide inadequate training in patient care delivery their graduates deserve the same salaries as others.

Responses to the resolution by state and national hospital and nursing organizations have been mixed. The American Hospital Association in a February 16, 1980, Board of Trustees resolution went on record against the 1985 proposal. They stated, in part:

> "The ANA 1985 proposal on entry into practice creates an artificial barrier to the production of nurses to meet the pressing need for nurses."

The AHA went on to strongly support continuance of all three forms of nursing education which prepare individuals to be registered nurses.

The Maryland Society of Nursing Service Administrators has reacted similarly, but in a milder mode. They said they "support the BSN (Bachelor of Science in Nursing) for entry to professional practice," but qualified the statement by adding that "many of our members feel we should stress the 1985 date is unrealistic and we do not see how the universities can prepare sufficient numbers of RNs by 1985 or the foreseeable future."

In considering this issue, the task force found itself supporting the broad concept of the ANA resolution. That support is tempered, however, by the task force members' acute awareness of the reality of the nurse shortage facing hospitals in this state. Pragmatically, the task force concluded that it is not possible at this time to endorse the 1985 resolution.

RECOMMENDATION: THE MARYLAND HOSPITAL ASSOCIATION, WITH RESPECT TO THE PROPOSED ANA RESOLUTION -- THAT THERE BE TWO LEVELS OF NURSING: PROFESSIONAL AND AN ASSISTING/TECHNICAL CATEGORY -- SHOULD INDICATE THAT 1985 IS A WHOLLY UNATTAINABLE TARGET DATE.

The task force realizes, however, that long before such a resolution could be implemented in Maryland, some official body must identify and differentiate between the skill levels of nurses with associate degrees, diplomas, and bachelor degrees. It is, in short, a delicate issue with far-reaching consequences. Even so, the task force is convinced the ground work must begin now.

## ORIENTING THE NEW NURSE

In the opinion of the task force, the early experiences and exposures of the new graduate nurse on his or her first job can be the most critical factor in keeping that individual in the profession in the long run.

The tone of that period of the nurses' orientation program can exert a powerful influence on the ultimate relationship between the nurse and the hospital.

It is of the utmost importance that all Maryland hospitals structure programs that provide a complete, realistic, and sensitive period of transition for the new graduate nurse from the controlled environment of the academic setting into the 24 hours a day, high-speed pace of the modern acute care or special hospital.

Adequate orientation is equally important for those nurses who have been out of the profession for some time and are returning to it.

New graduates, with the exception of those from hospital-based diploma schools, are accustomed to an orderly and regulated atmosphere geared to an emphasis on academics.

The student nurse, even in phases of clinical training, is under constant supervision and learns by providing maximum care for a limited number of patients. The typical staff nurse provides many kinds of care for many patients in an atmosphere of ever-changing pressures and responsibilities. This dichotomy between the academic and clinical setting can subject the new nurse to a kind of "reality shock" that leads to deep frustration, disillusionment, and the feeling of a lack of professional fulfillment.

In its investigation, the task force found the following to be true in many Maryland hospitals:

* Orientation programs range from thorough and sophisticated to shallow and spotty. Some institutions place great emphasis on in-depth orientation and others no importance at all.

* Many new nurses do not receive adequate information about the unique and particular administrative structure, and policies and procedures of their new employer. Every hospital is different; this failure to inform can be damaging to both the new nurse and the hospital.

* It is far from uncommon in Maryland hospitals for new graduates to be given charge nurse or supervisory responsibilities after a relatively short time on the job.

* Proper clinical supervision both to ease the new nurse

into the profession and allow the hospital to observe, evaluate, and improve the new nurse's job performance is largely lacking.

RECOMMENDATION: HOSPITALS SHOULD EXAMINE IN DETAIL THEIR ORIENTATION PROGRAM, PARTICULARLY FOR NEW NURSES, TO ENSURE A THOROUGH GROUNDING IN ALL ASPECTS OF THE INSTITUTIONS' OPERATION, STRUCTURE, POLICY AND PROCEDURES. THE PROGRAM SHOULD BE REEVALUATED ON A REGULAR BASIS FOR CURRENCY AND RELEVANCE.

RECOMMENDATION: THE HOSPITALS OF MARYLAND, POSSIBLY THROUGH THE MARYLAND HOSPITAL EDUCATION INSTITUTE, SHOULD BE GIVEN A FORUM TO COMPARE AND IMPROVE THEIR NURSE ORIENTATION PROGRAMS.

But beyond reviewing and restructuring orientation programs, new concepts must be invented.

One possibility the task force believes has great potential is an "internship" program for new nurses -- a formal arrangement between nursing schools and hospitals. Already in place in some institutions, the program should be given widespread consideration.

Such an internship program, standard throughout the state, should prepare the nurses to function with a realistic view of the hospital environment while exposing them to a variety of kinds of nursing in a clinical setting. An added dividend would be the new avenues of cooperation and communication that would be opened between hospitals and schools for such a program to be successful.

RECOMMENDATION: THE MARYLAND HOSPITAL ASSOCIATION SHOULD ASSIST HOSPITALS IN EVALUATING AND STRENGTHENING NURSE INTERNSHIP PROGRAMS. GREATER EFFORT SHOULD BE MADE TO DEMONSTRATE ADDITIONAL EXPERIMENTAL AND PROTOTYPE PROGRAMS BUILT ON THE EXPERIENCE GAINED TO DATE.

The task force believes strongly that good orientation programs can be the key to stemming early "burnout" of new nurses and helping to end the all too familiar story of the new nurse whose first few months in the real world of the modern hospital results in the loss of that individual to the profession, perhaps forever.

## SALARIES

Sooner or later, every discussion concerning the cause and cure of the nurse shortage centers around salaries.

Nurse organizations and others have done numerous studies comparing salaries for nurses with those of professionals in other fields. The hospitals of Maryland, in their dealings with state rate regulators, have pointed out repeatedly that because hospitals are labor intensive institutions with most of their work force comprised of nurses, adequate salaries for them are essential.

Explicitly and implicitly, the theory has been advanced that merely by increasing nurses' salaries, more individuals will be attracted to the field and remain in it. In a January 1979 statement released nationally, American Hospital Association President J. Alexander McMahon called for increased nurse salaries as one way to combat the shortage. Local and national nurse publications and, not surprisingly, organizing-campaign literature from labor unions draw attention to the lack of competitiveness in nurse salaries.

The dismal state of the national economy is an important element of the problem. The runaway inflation wracking the American economy has caused all incomes, not just those of nurses, to erode severely.

Nursing '79, a national magazine, noted in its September 1979 issue that, on a nationwide basis, nurse salaries increased about 14 percent between 1977 and 1979. But, the publication pointed out, the cost of living had jumped 16.8 percent during that same period.

But are salaries really the major influence on Maryland's supply of working nurses? Would an immediate across-the-board increase in salaries be sufficient to ameliorate all the other problems nurses say confront their profession?

This task force believes not. While salaries are a major concern and surely must be improved, they are only one factor, albeit an important one, influencing the current shortage.

An analysis of the information gleaned from the Maryland Hospital Association's January 1980 survey on the shortage indicates that simply raising salaries will not have a significant effect on the hospital's ability to attract and retain nurses.

Hospitals paying both higher and lower salaries for nurses were experiencing roughly similar vacancy rates. Only the two or three highest-paying institutions showed measurable, but not statistically meaningful, declines in vacancies.

A look at turnover rates leads one to much the same conclusion. The 1979 statewide turnover rate was about 27 percent. When the turnover rates are analyzed in terms of both basic wages and

total salary benefit packages offered by individual hospitals, the relationship is not significant. Total turnover rates for most Maryland hospitals range between 20.7 percent and 31.6 percent. As with nurse vacancies, only the highest-paying hospitals show a measurable drop in turnover when salaries are factored in. And, again, the difference is not statistically significant.

The statewide turnover rate for LPNs ranges between 22.8 and nearly 40 percent. Only in the LPN category does salary seem to affect turnover. This, however, is outweighed by the impact of the RN turnover.

Even though MHA's survey indicates that salaries do not affect the severity of the shortage hospitals are experiencing, they have an important impact on nurse morale.

Simply stated, a nurse who perceives that his or her pay is insufficient and not in line with the job done becomes dissatisfied and may leave the institution and the profession.

In Maryland, hospital rates are tightly regulated and institutions must battle for each new dollar in revenue. Beyond winning annual salary increases for all employees, including nurses, in an effort to keep pace with inflation, major adjustments in the basic salaries paid to nurses are going to come slowly.

RECOMMENDATION: HOSPITALS MUST NOT ONLY CONTINUE TO FIGHT FOR IMPROVED SALARIES, BUT MUST ADDRESS THE ECONOMIC CONCERNS OF NURSES BY TRYING TO DEAL EFFECTIVELY WITH OTHER INFLUENCES RELATED TO THE CURRENT SHORTAGE.

## WAGE COMPRESSION

Wage compression for nurses means that a new graduate can enter the profession at a relatively attractive salary -- generally more than that of a school teacher or similar professional -- but will reach maximum salary in a comparatively short time, generally in about five years.

The result is that an experienced hospital nurse may grow frustrated, feeling the salary does not reflect either the current experience or the responsibility.

This lack of salary growth potential may compel the nurse to search for another hospital with higher salaries or leave the profession entirely. Shifting of nurses between institutions does not increase the total available nurse supply and often only further frustrates the nurses.

Wage compression also stifles career development. Nurses may not aggressively seek to upgrade their skills if they do not see the reward of higher salaries or more responsibility. The rapid progress and intensity of medical technology makes it important that hospitals have nurses willing and eager to be trained in the newest technologies.

One way hospitals can deal with this problem is to ensure that its nurses perform only those tasks for which their degree of skill and training have prepared them.

In reviewing some innovations attempted by other hospitals across the country, the task force found that the development of levels of nursing within a hospital, based on skills and experience and reflected in salaries paid, could be an important step toward easing the effects of wage compression.

RECOMMENDATION: THE ADMINISTRATION OF EACH MARYLAND HOSPITAL, WORKING IN PARTNERSHIP WITH ITS NURSING STAFF, SHOULD STUDY THE LINKAGE BETWEEN NURSE RESPONSIBILITIES AND SALARIES AND STRIVE FOR A SYSTEM OF SALARIES COMMENSURATE WITH RESPONSIBILITY AND EXPERIENCE.

But as previously pointed out, salaries and wage compression, while surely influencing the way a nurse perceives his or her profession, are not the whole story.

As its inquiry progressed, the task force found that intangibles such as professional fulfillment and career development played a nearly equal role in shaping nurses' attitudes toward their profession and the hospital.

## PROFESSIONAL FULFILLMENT

Hospital nurses, besides being highly trained, also are highly motivated individuals. They are well educated and feel competent to deliver patient care in partnership with physicians and other health professionals. At the same time, nurses in the hospital setting realize that they are responsible for the major portion of patient care. It is part of their definition of "professional fulfillment" that they feel they have rendered the best care they are capable of in a work environment where they are respected and considered.

A survey summarized in the January 1979 issue of Hospitals reflected this attitude. The study sought to pinpoint which job rewards are most important to a wide range of health care professionals, including RNs and LPNs. Seventy-four percent of the registered nurses surveyed and forty-eight percent of the licensed practical nurses said "a feeling of job importance" is their most meaningful professional reward and they ranked it ahead of promotion.

Creating a work environment that embodies these concepts is clearly the responsibility of the hospital.

The task force discussed this problem with a variety of individuals in and allied to the nursing profession. A number of principles emerged which, if practiced in all Maryland hospitals, would significantly improve the work environment from the nurses' point of view.

* The entire institution, including administration and medical staff, must be committed to the concept of the nurse as an equal partner in the delivery of quality patient care.

* The nursing department must be a component of the hospital's decision-making process in areas affecting patient care, the practice of nursing, and the assurance of quality.

* The nursing department must be an integral part of budget and program planning and resource allocation.

* The nursing staff must be involved in setting the hospital's professional practice policies for the individual patients.

As extensively trained professionals, nurses can and must contribute to hospital patient care policies. The nature of their training and constant exposure to the patients well equips them to integrate knowledge and apply it to problems.

RECOMMENDATION: HOSPITALS SHOULD REVIEW THEIR ADMINISTRATIVE STRUCTURES -- BUDGET AND PROGRAM PLANNING, PATIENT CARE AND

QUALITY ASSURANCE COMMITTEES, INSTITUTIONAL PLANNING COMMITTEES AND OTHER KEY DECISION-MAKING BODIES -- TO ENSURE THAT NURSE MANAGEMENT PARTICIPATES AT ALL LEVELS OF DECISION MAKING.

The task force believes emphatically that this is an important element in giving hospital nurses a sense of professional fulfillment. A high quality support system for the nursing staff and an institutional and professional administration in which they have a heeded voice will encourage nurses to work at peak ability, expand their role in the hospital, concentrate their abilities, and seek to upgrade their skills.

Another issue in professional fulfillment is the need for institutions to be more sensitive to those factors affecting job satisfaction, to demonstrate supportive attitudes toward the recognition of nurses, and to build professional equality between nurses and other individuals in the hospitals. To create and sustain a satisfying work environment conducive to retention, hospitals must ensure that physician and management attitudes are in line with the tenor of the times. The days of the "handmaiden" mentality have ended. Yet, all too often nurses still are subjected to that outmoded behavior. Sensitivity to and recognition of this concern will go far in creating a positive environment.

RECOMMENDATION: THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND SHOULD ESTABLISH, AS PART OF ITS CONTINUING EDUCATION FOR PHYSICIANS, A PROGRAM TO IMPROVE AND HEIGHTEN HUMAN RELATIONS SKILLS WITH THE OBJECTIVE OF INCREASING PHYSICIAN SENSITIVITY TO THE DIGNITY AND ABILITIES OF THEIR HEALTH CARE COLLEAGUES.

## CAREER GROWTH

A potent factor in any individual's job success is a sense of potential -- the idea that an individual who does superior work, exhibits dedication to an institution, and is ambitious has a future within the institution.

Nurses are no different.

While certainly not every nurse aspires to management, some do and their potential should be recognized and nurtured. Most nurses want to improve, progress and excel in the area for which they are trained: the direct delivery of patient care.

Nurses who wish to focus their career on and remain in a clinical setting should have as clear a course for upward mobility as nurses who choose management as their goal.

It is to these dual career ladders in nursing -- management and clinical -- that hospitals must respond if they are to give the nurse, whatever his or her ultimate future goals, a sense of potential within the institution.

The task force examined several efforts to devise a "clinical ladder" of professional progression for nurses.

One Midwestern hospital implemented a five-level clinical ladder and saw extremely positive results in terms of reduced rates of turnover. Each level carried with it increased financial and productivity incentives, and the higher status which accompanies an individual's achieving a new stratum of expertise.

The five levels were:

* Staff Nurse - Entry level. General nursing knowledge, ability, and skill. The new nurse graduate.

* Staff Nurse II - General nursing ability, knowledge, and skill, supplemented by experience in practice.

* Clinical Nurse I - The base level of specialized clinical ability and skill, based on nurse practice and advanced training.

* Clinical Nurse II - Specialized clinical knowledge, ability, and skill based on clinical practice and advanced education.

* Clinical Nurse Specialist - In-depth clinical expertise with a specialized advanced degree and seasoned practice in a special clinical area.

Each succeeding level requires greater specialization and training, thus the hospital makes the most of its nursing staff

resources.

In reviewing these and other types of "clinical ladders," the task force found excellent potential in such structures. Properly designed, implemented, and explained to nursing personnel, with recognizable salary incentives, they can be an important step toward reducing turnover rates and guaranteeing opportunities for meaningful career growth.

The task force believes that the time to experiment with clinical ladders is long past. The shortage of nurses and the instability of the work force make such an attempt more relevant than ever.

RECOMMENDATION: HOSPITALS SHOULD STRONGLY CONSIDER THE ESTABLISHMENT OF A SYSTEM OF CLINICAL ADVANCEMENT TO ENCOURAGE NURSES TO FURTHER THEIR EDUCATION AND BROADEN THEIR SKILLS AND SHOULD LINK EACH STEP OF THE LADDER TO COMMENSURATE SALARY AND BENEFIT IMPROVEMENTS.

For those nurses who want to pursue careers in management, the course is much clearer. The nurse progresses to supervisory and unit management and can eventually become assistant director and director of nursing.

The task force looked closely at how individuals become managers in hospitals. While in some institutions the movement into management is based on experience and education, it is far more often the case that the staff nurse becomes a supervisor or manager more by inclination and happenstance than anything else.

Most likely, the exceptional staff nurse is considered the best candidate to take on supervisory or management duties. The result is that an individual with no training or talent for management is thrust into a job where the individual is expected to produce and use skills not yet acquired.

Management is an individual, definable skill. The first-rate staff nurse may have the potential to become an excellent manager, but that is all -- the potential. One of the most frequent assumptions in hospital management is that a good staff nurse will make a good head nurse and the good head nurse a good supervisor and so on. This is in error.

The task force found one of the greatest areas of neglect by Maryland hospitals to be their efforts to spot and provide solid training to individuals interested in or exhibiting the potential to move into management.

Competent hospital nurse management at all levels is one of the most important components of a productive, satisfied nursing staff. All the efforts to attract qualified personnel and all the incentives and benefits to retain them are useless if the institution does not provide management to its nurses on whom they can rely and in whom they can trust.

RECOMMENDATION: HOSPITALS SHOULD SUPPORT AND FOSTER THE USE OF MULTILEVEL MANAGEMENT TRAINING PROGRAMS FOR NURSES ENTERING AND OCCUPYING SUPERVISORY POSITIONS. PARTICULAR EMPHASIS SHOULD BE PLACED ON EARLY RECOGNITION AND DEVELOPMENT OF POTENTIAL MANAGEMENT TALENT.

Such programs should be aimed at exposing the nurse-manager to the most current techniques and theories. Further, the training should be followed up by a conscientious program to allow the nurses to put what they've learned into on-the-job practice.

In the task force's opinion, the Maryland Hospital Education Institute can and should provide leadership to the hospitals in designing programs for clinical and management training for nurses. The efforts of the Institute should reflect the gravity of the nursing shortage situation in Maryland today.

RECOMMENDATION: THE MARYLAND HOSPITAL EDUCATION INSTITUTE SHOULD ASSIST NURSES AND HOSPITALS IN IDENTIFYING THE KEY CLINICAL AND MANAGEMENT EDUCATION NEEDS OF NURSES AND THEN DEVISE A LONG-RANGE PROGRAM TO MEET THOSE NEEDS.

## HOSPITAL PERSONNEL POLICIES

An area of particular concern and attention by the task force was hospital personnel policies -- the general guidelines and rules established by an institution for managing its work force.

The character of American workers is changing, as are the workers' perceptions of their jobs as a part of an overall life-style. The decade of the 1970s saw a new concern with personal fulfillment and satisfaction on the job and more individual attention to blending the requirements of the job with other life goals. Americans were told that workaholics and others who allowed themselves to be overly affected by stress due to job demands were candidates for heart attacks, ulcers, and a variety of nervous and psychological disorders.

In the nursing profession, it is called burnout.

Helping nurses to successfully integrate professional and personal lives is a challenge hospitals must meet. Their failure to do so can only serve as a wedge, creating an even larger gap between nurses and the institutions that need them most.

It must be pointed out that confronting this challenge is difficult for any institution, but particularly for a hospital.

Even though hospitals are labor intensive and thus, in theory, should devote much effort to keeping their work force enthusiastic and productive, their mission is one of providing a critical around-the-clock service to people desperately in need of that service. Thus the goal of meeting the needs of its work force often collides with the mission of the hospital: continuous, quality patient care. Perhaps the most visible example of this is the difficulty virtually all hospitals have in staffing evening, night, and weekend shifts.

The problems surrounding evening and night shift coverage are nearly unique unto themselves. Historically the night nurse, and frequently those on evening coverage, are treated as second-class citizens. Staffing coverage is at a minimum. Job responsibilities and functions are usually expanded to include many nonnurse duties. This occurs primarily because nurses are the predominate workers on those shifts.

The first shifts to experience any shortage or turnover increase are those two. Yet, little special effort is given to developing educational programs focusing on the unique role, involvement, and appropriate use of personnel on the evening and night shifts.

Basic nursing education programs fail to emphasize the importance of evening and night duties. Schools should increase the use of hospital facilities for student nurse scheduling on full eight-hour shifts, night, and weekend rotations. Adequate

compensation and faculty support would also be a prerequisite to this activity.

RECOMMENDATION: HOSPITALS, WORKING IN PARTNERSHIP WITH NURSING EDUCATION PROGRAMS, SHOULD GIVE SPECIAL ATTENTION AND DEVOTE APPROPRIATE RESOURCES TO PROVIDING STUDENT NURSES WITH A COMPREHENSIVE VIEW OF THE HOSPITAL, INCLUDING PRACTICAL EXPERIENCE ON ALL SHIFTS AND WEEKEND WORK.

While some Maryland hospitals have taken a flexible and enlightened attitude toward adjusting personnel policies to help their nursing staffs successfully merge their professional and personal lives, the majority are lagging in this area.

Personnel policies, selection of benefits and work scheduling should be viewed, in the task force's opinion, not as institutional dicta in the hospital, but rather as tools which, in the hands of an open-minded administration, can help fashion a happier, more productive work force.

Nurses, particularly those with families, find that working night or evening shifts sometimes causes insurmountable family problems. Therefore, the nurse is reluctant to seek hospital employment. Yet the hospital must have nurses to provide 24-hour patient care.

Currently, most hospitals operate with the traditional three eight-hour shifts structure. In light of the reality of new work attitudes, this strikes the task force as arbitrary and outmoded.

With a careful evaluation of the particular character and needs of the individual institution, hospitals should consider techniques such as more shifts per 24-hour period or longer shifts and fewer work days. It is recognized that these concepts have implications for the total hospital environment -- physician rounds, ancillary service departments and nonnursing personnel -- still, they are worthy of consideration.

Four shifts of six hours each -- or two shifts of eight hours and two of four hours -- could attract some nurses who would want to work part-time if well-paying hospital positions were available.

Use of the primary care concept which gives the responsibility to a single nurse, for example, could make it easier for management to make the most of its staff resources.

RECOMMENDATION: HOSPITALS OF MARYLAND SHOULD CONSIDER THE USE OF FLEXIBLE WORK SHIFTS TO GIVE THE NURSE MORE OPPORTUNITY TO ADJUST PROFESSIONAL AND PERSONAL NEEDS.

The creative use of benefits has been largely overlooked in most hospitals.

Some nurses, covered under medical plans or retirement systems of other family members, could waive those hospital programs and receive the dollar difference. Other restructuring of benefit plans is possible and should be explored, again with the individual nature of the institution in mind.

More input from nurses about their benefit alternatives could help hospitals plan realistic responses to the challenges of building a positive work environment.

RECOMMENDATION: HOSPITALS SHOULD CONSIDER BENEFIT OPTIONS FOR NURSES, PROVIDING OPPORTUNITIES FOR NURSES TO HAVE A VOICE IN THE BENEFITS OFFERED THEM, AND A DECISION IN WHAT THEY CAN ACCRUE OR WAIVE.

## TEMPORARY NURSE AGENCIES

Virtually all of the issues cited so far in this report can be influenced and dealt with by either hospitals or the nursing profession.

One issue, however, is distinct in its dimension and is intensifying and exacerbating the shortage of hospital nurses in Maryland.

The temporary nurse staffing agencies, by offering more flexible schedules, fewer of the inconveniences of unpopular night and weekend work and, often, more money are siphoning nurses off hospitals' potential staff market.

A survey of nurses who work for temporary agencies, studied by the task force, confirmed this statement. The nurses polled cited control over work schedules as the single most important factor motivating them to sign with temporary nurse agencies: freedom to work part-time; to choose not only their shift, but the hospital and hospital unit as well.

Fiscal factors such as salary, health insurance, retirement plans, educational benefits, sick leave, and vacations rarely were mentioned as important considerations. The temporary agencies seemed particularly attractive to new graduates and younger nurses not that much concerned with seniority.

Operators of these agencies claim that offering flexible schedules makes more nurses available to hospitals. They contend that because they allow nurses to better blend personal and professional lives, the nurses are a more dependable resource to the hospital.

Critics of these agencies allege that the quality of care delivered by a temporary nurse is less satisfactory since the nurse is unfamiliar with the day-to-day operation of the institution. Opponents also point to negative effects the temporary nurse may have on overall staffing patterns in the hospital. The temporary agency nurse often is limited to basic nursing duties, causing not only a heavier work load for staff nurses, but frustration for the agency nurse.

The task force believes that the reality of the extent of the nurse shortage means that the temporary agencies are going to be a part of the hospital scene for the foreseeable future.

While there are constructive and decisive actions hospitals can take to greatly lessen their dependence on these agencies, the immediate challenge is to ensure that the temporary agency nurse is qualified, capable, and as prepared as possible to function in the individual institution.

Some nursing organizations have proffered guidelines to help hospitals make the most efficient use of temporary nurse agencies.

They urge hospitals to closely question agencies about how they choose the nurses who work for them, the nurses' training, and malpractice coverage.

But beyond these broad areas, hospitals must review the educational and professional background of these nurses, particularly in light of the individual institutional policies and needs. The aim always should be the highest quality patient care.

Temporary agencies also have a responsibility to police their ranks. While some organizations are cognizant of the need for assuring that the right individual is assigned to the right position, this level of integrity may not exist throughout the industry.

RECOMMENDATION: ALL MARYLAND HOSPITALS USING TEMPORARY NURSE AGENCIES SHOULD ADHERE TO RECOGNIZED GUIDELINES WHICH DELINEATE THE PROPER MECHANISM AND PROCEDURES FOR ACCEPTANCE, ORIENTATION, ASSIGNMENT, AND/OR EVALUATION OF THE INDIVIDUAL AGENCY NURSE.

The task force found great variances in the policies and procedures used by Maryland hospitals for selecting, assigning, evaluating and, in particular, orienting the temporary nurse.

Better procedures, the task force believes, would have a direct effect on the institution's quality assurance and risk management efforts.

While hospitals must resign themselves to use of temporary agency nurses as a fact of life, they can lessen their dependence on these commercial enterprises and give themselves more control over the quality of temporary services.

The Illinois Hospital Association established a medical registry under the auspices of its subsidiary, Illinois Hospital Joint Venture, Inc. The registry is designed to provide hospitals with qualified staff, including nurses on a temporary, on-call, around-the-clock basis. Its objective is to alleviate staff shortages due to vacations, personnel vacancies, temporary work load increases, and absenteeism.

The advantages to nurses who join the registry are numerous. No one is required to work and fluid communication is encouraged between registry personnel and registry director about days, hours, hospitals, clinical settings, and other preferences.

Employees can request certain kinds of duty such as special or intensive care and the registry makes a deliberate and conscientious effort to match the employees' desires with the hospitals' needs. It is a hospital's prerogative to reject a person, place, or time.

One element of the Illinois project is that registry personnel are encouraged to participate in continuing education programs offered by any participating hospital. Coupled with the required

orientation program, temporary nurses in Illinois are given access to some form of professional development.

Several hospitals in Maryland have created their own individual in-house nursing pools, permitting nurses to choose shifts and receive higher wages in lieu of some benefits. But again, such innovations, while commendable, are scattered.

The task force believes an effort similar to the one in Illinois deserves consideration in Maryland. Because of the state's unique geography and limited transportation systems it may not be feasible as a statewide endeavor. Regional registries operated by groups of hospitals have genuine potential, however.

RECOMMENDATION: HOSPITALS WITHIN THE SAME GEOGRAPHIC REGION SHOULD EXAMINE THE ADVANTAGES OF REGIONAL POOLS TO WIDEN THE SUPPLY OF NURSING PERSONNEL AVAILABLE TO ALL.

RECOMMENDATION: INDIVIDUAL HOSPITALS SHOULD ASSESS THE VALUE OF CREATING IN-HOUSE NURSING POOLS.

## NURSING AS A PRIORITY OF STATE GOVERNMENT

It should be apparent from the recommendations contained so far in this report that Maryland hospitals who employ nurses and the community colleges, diploma schools, and universities who educate them have much to do to begin eliminating the shortage now crippling the state.

But several suggestions in this document also are directed at the state government -- an institution whose role in the condition of the nursing profession in Maryland is, in the task force's view, vastly underrated.

The state of Maryland sets policy and practice for education at all levels. Through the Board of Examiners of Nurses, it examines for competency and licenses nurses. The State Department of Health and Mental Hygiene promulgates laws, regulations, and policies which strongly influence the practice of nursing. Via the Maryland Health Services Cost Review Commission, the state maintains tight regulatory control over increases in the cost of health care. The task force believes the state government could be a strong and productive partner in helping the health care industry deal with the nurse shortage.

In studying the recently completed first edition of the Maryland State Health Plan, the task force was disturbed that nursing, as a critical component of the health care system, was not given substantive treatment in the Plan. This was particularly puzzling because the state itself is an employer of nurses in a variety of settings and surely must feel the effects of current conditions.

A nursing section in the State Health Plan is essential. The new Maryland Commission on Nursing, which will soon commence work under the authority of the state legislature, provides an excellent vehicle for fashioning a new nursing policy and priority for the state government.

RECOMMENDATION: THE TASK FORCE URGES THE STATE HEALTH PLANNING AND DEVELOPMENT AGENCY TO TAKE THE NECESSARY STEPS TO AMEND THE STATE HEALTH PLAN TO INCLUDE A COMPONENT ON NURSING RESOURCES. WE FURTHER URGE THAT THIS BE DONE IN CLOSE COOPERATION WITH THE NEW MARYLAND COMMISSION ON NURSING.

The nursing portion of the Plan should outline the roles, responsibilities, and goals of all agencies of state government which deal with and influence the nursing profession.

At the beginning of this report, the task force related its early attempts to collect data on the numbers, kinds, and professional status of nurses in Maryland.

The task force was surprised at the dearth of data available from all public and private sources, but particularly from the Board

of Examiners of Nurses and the State Health Department. Most of the information uncovered was either obsolete or incomplete. In some cases, it simply had never been collected.

The Board of Examiners of Nurses is the logical agency to build and maintain an accurate profile of the status of the nursing profession. This small agency, however, suffers from skimpy funding and inadequate staffing. To do an adequate job, it must have adequate funding.

Further, nurses in Maryland are relicensed only every two years and at a minimal fee. Even during the license renewal process, the collection of information is done without thought of its importance as a tool for evaluating nursing practice patterns.

RECOMMENDATION: THE GOVERNOR SHOULD REQUEST THE NECESSARY FUNDING FROM THE MARYLAND GENERAL ASSEMBLY TO INCREASE THE STAFF AND RESOURCES OF THE MARYLAND BOARD OF EXAMINERS OF NURSES. THE GOVERNOR SHOULD FURTHER INVESTIGATE WHAT LEGISLATION MIGHT BE NECESSARY TO OBTAIN, AS A REQUIREMENT FOR RELICENSING, BASIC DATA ON THE DISTRIBUTION AND PROFESSIONAL STATUS OF NURSES.

## AFTERWORD

## NURSING AT THE MILLENNIUM

The creation by the General Assembly of the Commission on Nursing was a milestone, in the opinion of the task force. For all the problems and predicaments the task force encountered as it worked, it became apparent that the nurse shortage in Maryland is less severe than in many areas of America.

While shrinking financial resources, particularly from government, are deeply hurting nursing in other states, Maryland remains in secure financial condition.

Maryland's reputation as a center for health care and medical innovation makes the prospects for finding meaningful solutions to today's problems exceedingly bright.

This makes the new Commission particularly timely and relevant.

The Commission has the opportunity to provide genuine, relatively immediate direction for nursing in Maryland. This is much needed.

But perhaps even more important, the Commission, anticipating future needs and resources, can devise the philosophies, propose the policies, and stimulate the kind of debate, discussion, and innovation that will be critical in keeping the profession of nursing in Maryland vital and high in public esteem.

The task force pledges its cooperation and support for the Commission's work.

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TABLE A

ANALYSIS OF VACANCIES

| | CATEGORY | N | TOTAL VACANCIES FTE | PERCENT VACANCIES |
|---|---|---|---|---|
| | State Average | 48 | 24.9 | 13.8 |
| I. | Rural | 15 | 15.5 | 13.2 |
| | Urban | 33 | 29.2 | 14.1 |
| II. | Baltimore | 26 | 27.8 | 14.8 |
| | Washington, D.C. | 10 | 27.5 | 14.5 |
| | Eastern Shore | 5 | 18.1 | 12.1 |
| | Western Maryland | 7 | 14.9 | 10.7 |
| III. | General | 43 | 26.7 | 13.2 |
| | Specialty | 5 | 9.3 | 18.7 |
| IV. | Beds | | | |
| | 120 and under | 11 | 11.1 | 16.6 |
| | 121-240 | 14 | 24.3 | 16.8 |
| | 241-360 | 14 | 25.6 | 10.9 |
| | 361+ | 9 | 41.4 | 9.8 |
| | State Average | 45 | 25.2 | 13.7 |
| V. | No Interns/ Residents | 32 | 22.2 | 12.9 |
| | Interns/ Residents | 13 | 32.9 | 15.5 |
| VI. | LOS (Days) | | | |
| | State Average | 43 | 26.7 | 13.2 |
| | 6.20 and under | 3 | 9.5 | 10.1 |
| | 6.21-7.50 | 12 | 18.6 | 12.0 |
| | 7.51-8.70 | 15 | 30.0 | 12.5 |
| | 8.71-10.00 | 8 | 38.5 | 14.0 |
| | 10.01+ | 5 | 27.7 | 18.9 |
| VII. | Wage Rate (No Benefits) | | | |
| | State Average | 42 | 27.1 | 13.7 |
| | $5.40 or less | 1 | 21.0 | 12.1 |
| | $5.41-$6.00 | 4 | 8.6 | 11.2 |
| | $6.01-$6.60 | 7 | 19.1 | 14.6 |
| | $6.61-$7.20 | 20 | 32.6 | 15.6 |
| | $7.21-$7.80 | 8 | 32.2 | 10.9 |
| | $7.81+ | 2 | 19.1 | 7.9 |
| VIII. | Total Rate (With Benefits) | | | |
| | State Average | 42 | 22.2 | 12.4 |
| | $6.40 or less | 3 | 10.0 | 12.3 |
| | $6.41-$7.20 | 6 | 15.6 | 13.8 |
| | $7.21-$8.00 | 19 | 32.3 | 15.3 |
| | $8.01-$8.80 | 11 | 30.2 | 12.9 |
| | $8.81+ | 3 | 22.7 | 7.5 |

TABLE A

ANALYSIS OF VACANCIES

Introduction

This table provides the total vacancies (RN and LPN) and the percent vacancies of the nursing work force. Eight distinct groupings were used to develop the statistics.

I. Urban/Rural:

Data was submitted by 48 hospitals, with 15 in the rural classification and 33 in the urban area.

On the average, there are 24.9 total vacancies (RN plus LPN) per hospital. This divides into 15.5 vacancies in the rural areas and 29.2 in the urban.

II. Specific Regions:

The second group breaks out 48 hospitals by 4 discrete regions, with the number of hospitals in the region in the second column.

1) Baltimore/Metro Area
2) Washington, D.C./Metro Area
3) Eastern Shore
4) Western Maryland

For these regions, the average vacancy rate is 24.9 FTE per hospital, with a vacancy rate of 13.8%.

The percentages suggest that urban and rural hospitals are experiencing approximately the same shortage.

| | Total Vacancies (FTE) | Percent Vacancies % |
|---|---|---|
| Baltimore/Metro | 27.8 | 14.8 |
| Washington, D.C./Metro | 27.5 | 14.5 |
| Eastern Shore | 18.1 | 12.1 |
| Western Maryland | 14.9 | 10.7 |

III. General/Specialty:

Forty-eight hospitals were classified as general or specialty hospitals. Specialty here refers to the fact that the hospitals care for a particular type of patient. Of the total, 43 were classified as general, with 5 as specialty.

The results show that general hospitals experienced 26.7 FTE (13.2%) vacancies, and specialty institutions 9.3 vacancies (18.7%). This might indicate that the problem is more severe in specialty hospitals than in general institutions.

IV. Number of Beds:

The 48 hospitals were divided into 4 bed-size categories. Hospitals with fewer than 120 beds had 11.1 vacancies (16.6%); 121-240 beds had 24.3 vacancies (16.8%); 241-360 beds had 25.6 vacancies (10.9%) and 361+ had 41.4% (9.8%).

Unsurprisingly, the total number of vacancies increase with the hospital size. However, percentage differences appear to suggest that the larger hsopitals are not suffering as severely as the smaller institutions.

V. Interns and Residents:

Data was submitted by 45 hospitals concerning interns and residents. Of these, 32 indicated interns and residents are not employed in the hospital, and 13 specified that interns and residents are employed.

The data shows a higher number of vacancies for hospitals with interns and residents (32.9% vs. 22.2%). This, however, may be due to the larger hospitals having interns. The difference decreases when viewing the percentage of vacancies (12.9% vs. 15.5%).

VI. Length of Stay (days):

Data for 43 hospitals was adequate to correlate with LOS data. With the state average at 26.7 FTE (13.2%) a higher LOS corresponds to a higher vacancy rate except for the last category (9.5 to 38.5 FTE). The last group, 10.01+ days, shows a drop in the total number of vacancies. However, the percentage vacancies increase with higher LOS (10.1% to 18.9%).

VII. Wage Rate:

The HSCRC Wage and Salary Survey for 1978 was correlated with vacancies. Two major reservations with the wage data are:

1) it is the average rate, which can be misleading;
2) the data is two years old.

The wage data excludes employee benefit costs (This will be included in the next category, Total Rate.)

Forty-two hospitals were correlated with the wage rates.

Excluding the last category because it is small (only 2 hospitals), it does not appear that the number of vacancies declines with higher salaries. Percentage vacancies increase to a peak at $6.61-$7.20 (15.6%) and then begin to drop to 10.9% and 7.9%.

Table A
Analysis of Vacancies



VIII. Total Rate:

Total rate data includes the employee benefit costs as submitted to HSCRC. The vacancy data shows that vacancy rate is unaffected by the total rate up to a threshold point ($7.21-$8.00), at which time the vacancy rates slightly decline.

The vacancy rate also shows this effect. The percentage climbs to 15.3% at $7.21-$8.00 and then slightly declines in the next two categories.

TABLE B

ANALYSIS OF TURNOVER

| | CATEGORY | N | RN TURNOVER (%) | LPN TURNOVER (%) | TOTAL (%) |
|---|---|---|---|---|---|
| | State Average | 47 | 31.6 | 26.7 | 29.1 |
| I. | Rural | 15 | 24.2 | 30.7 | 25.2 |
| | Urban | 32 | 35.1 | 24.7 | 30.1 |
| II. | Baltimore | 26 | 34.7 | 23.7 | 29.8 |
| | Washington, D.C. | 9 | 34.8 | 39.7 | 36.3 |
| | Eastern Shore | 5 | 24.1 | 15.4 | 20.5 |
| | Western Maryland | 7 | 21.4 | 30.4 | 23.3 |
| III. | General | 42 | 31.0 | 26.2 | 28.2 |
| | Specialty | 5 | 37.0 | 32.3 | 36.6 |
| IV. | Beds | | | | |
| | State Average | 47 | 27.9 | 26.7 | 27.6 |
| | 120 and under | 10 | 34.4 | 45.0 | 36.7 |
| | 121-240 | 14 | 24.9 | 19.6 | 23.7 |
| | 241-360 | 14 | 28.6 | 21.7 | 27.2 |
| | 361+ | 9 | 24.2 | 23.3 | 24.0 |
| V. | State Average | 46 | 31.6 | 26.6 | 29.0 |
| | No Interns/ Residents | 33 | 31.9 | 27.5 | 31.0 |
| | Interns/ Residents | 13 | 31.5 | 26.2 | 28.3 |
| VI. | LOS(Days) | | | | |
| | State Average | 42 | 31.0 | 26.2 | 28.2 |
| | 6.20 and under | 2 | 21.3 | 38.7 | 24.6 |
| | 6.21-7.50 | 12 | 23.2 | 26.0 | 24.3 |
| | 7.51-8.70 | 15 | 28.5 | 29.4 | 27.9 |
| | 8.71-10.00 | 8 | 52.4 | 20.5 | 37.4 |
| | 10.01+ | 5 | 26.6 | 19.7 | 25.2 |
| VII. | Wage Rate (No Benefits) | | | | |
| | State Average | 41 | 30.6 | 26.7 | 27.7 |
| | $5.40 or less | 1 | 19.1 | 22.8 | 20.0 |
| | $5.41-$6.00 | 4 | 29.6 | 39.5 | 31.6 |
| | $6.01-$6.60 | 7 | 20.2 | 23.2 | 19.6 |
| | $6.61-$7.20 | 19 | 37.7 | 27.3 | 31.9 |
| | $7.21-$7.80 | 8 | 26.3 | 22.8 | 25.4 |
| | $7.81+ | 2 | 23.1 | 12.1 | 21.4 |
| VIII. | Total Rate (With Benefits) | | | | |
| | State Average | 41 | 30.6 | 26.0 | 27.7 |
| | $6.40 or less | 3 | 26.7 | 40.9 | 29.3 |
| | $6.41-$7.20 | 6 | 27.6 | 28.0 | 26.7 |
| | $7.21-$8.00 | 18 | 37.0 | 26.0 | 30.8 |
| | $8.01-$8.80 | 11 | 24.6 | 23.5 | 24.0 |
| | $8.81+ | 3 | 23.7 | 15.9 | 22.5 |

TABLE B

ANALYSIS OF TURNOVER

Introduction

This table compares the RN, LPN, and total turnover for 8 categories. Turnover was defined as the number of separations divided by the nursing work force times 100.

I. Urban/Rural:

Analytical data was submitted by 47 hospitals. Of these, 15 were in the rural category and 32 in the urban grouping. RN turnover was slightly higher in the urban area (35.1% vs. 24.2%); LPN was higher in the rural (30.7% vs. 24.7%), with total turnover in the urban region almost 5% above that of the rural area.

II. Distinct Regions:

The 47 hospitals were divided into 4 distinct regions with the following number of hospitals in each group:

| Region | Number of Hospitals |
|---|---|
| Baltimore/Metro | 26 |
| Washington, D.C./Metro | 9 |
| Eastern Shore | 5 |
| Western Maryland | 7 |

The data shows that the 2 urban areas have approximately the same RN turnover (34.7% and 34.8%), with the rural areas also close together (24.1% and 21.4%). LPN data shows that the Washington, D.C. area has the highest turnover, with Baltimore the second highest (39.7% vs. 23.7%). The rural region shows a marked difference, with Western Maryland almost twice that of the Eastern Shore (30.4% vs. 15.4%). Total turnover shows that Washington, D.C. has the highest (36.3%); then Baltimore (29.8%); Eastern Shore (20.5%); and, finally, Western Maryland (23.3%).

III. General/Specialty:

The 47 hospitals were then divided into general and specialty categories. Specialty was defined as those hospitals dealing primarily with a specific type of patient. Forty-two general hospitals were compared with 5 specialty hospitals.

In the 3 categories -- RN TURNOVER, LPN TURNOVER, and TOTAL -- specialty hospitals show a higher turnover percentage than the general institutions.

| | |
|---|---|
| RN TURNOVER -- | 37.0% vs. 31.0% |
| LPN TURNOVER -- | 32.3% vs. 26.2% |
| TOTAL | 36.6% vs. 28.2% |

IV. Number of Beds:

Data from the 47 hospitals was divided into 4 bed-size categories: 120 beds and under, 121-240, 241-360, and 361+.

In all cases, the smallest category (120 beds and under) indicates a higher turnover rate for RN, LPNs, and the total. It is interesting that the 3 remaining categories are experiencing approximately the same turnover.

V. Interns/Residents:

Information was submitted by 46 hospitals. Of these, 33 indicated interns and residents were not present in the hospital; 13 stated interns and residents were present.

The data shows that the presence or absence of interns did not noticeably affect the turnover.

| | RN | LPN | TOTAL |
|---|---|---|---|
| No Interns/Residents | 31.9 | 27.5 | 31.0 |
| Interns/Residents | 31.5 | 26.2 | 28.3 |

VI. Length of Stay:

Data that could be correlated with turnover was reported by 42 hospitals.

RN turnover seemed to peak at 8.71-10.00 days as LOS increased. After 10.01+ days, RN turnover decreased to 26.6%. LPN turnover started out high at 38.7% for hospitals with an LOS under 6.20 days and then fluctuated up and down. Total turnover, like the RN statistics, rises to a peak at 8.71-10.00 days and then drops to 25.2%.

VII. Wage Rates:

The HSCRC Wage and Salary Survey for 1978 was correlated with turnover data for 41 hospitals. Two major reservations with the wage data are:

1) it is the average rate;
2) the data is two years old.

The wage rate excluded employee benefit costs.

The RN turnover data shows turnover increasing as the wage rate increases up to $6.61-$7.20 per hour and then declining. LPN and the total data fluctuate and do not show a steady increase from the beginning.

Table B
Analysis of Turnover



VIII. Total Rate:

The 41 hospitals' wage and salary data was correlated with the total rate, which includes employee benefit costs.

Like the wage rate data, RN turnover rises to a peak at the $7.21-$8.00 category (37.0%) and then declines. LPN and total turnover rates do not show this same constant increase with the total rate. Instead, the total rates fluctuate though a peak is reached at the $7.21-$8.00/hour category.